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Person-Related and Treatment-Related Barriers to Alcohol Treatment

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Abstract

Treatment underutilization by persons with alcohol use disorder is well-documented. This study examined barriers to treatment at the latter stages of the treatment-seeking process, which was conceptualized as recognizing the problem, deciding that change is necessary, deciding that professional help is required, and seeking care. All participants identified themselves as having a drinking problem that was severe enough to warrant treatment. Differences between those who had (Treatment Seekers) and those who had not (Comparison Controls) sought treatment were evaluated, including the experience of person-related (e.g., shame) and

treatment-related (e.g., cost) barriers. Person-related barriers were more commonly endorsed by both groups than treatment-related barriers. Comparison Controls were more likely to endorse both types of barriers, especially the preference for handling the problem without treatment. Treatment-related barriers were less relevant than person-related barriers at the latter stage of help seeking. The significance of barriers endured after accounting for other differences, such as drinking-related negative consequences. Treatment implications are discussed.

Keywords

Alcohol treatment barriers; Treatment seeking

1. Introduction

Although psychosocial treatments result in significant and sustained improvement ([Bunn, Booth, Loveland Cook, Blow, & Fortney, 1994](#)), adults with alcohol problems underutilize them. Whereas about 8% of the respondents to a nationally representative U.S. survey met criteria for alcohol use disorder in the prior year, less than one fourth of those problem drinkers had received formal treatment ([Narrow et al., 1993](#), [Regier et al., 1993](#)). Similar figures have been reported in Canada ([Bland, Newman, & Orn, 1997](#)). [Olfson, Kessler, Berglund, and Lin \(1998\)](#) found that persons with substance use disorders were more likely to postpone treatment seeking than other persons with diagnosable psychiatric illnesses. [Kessler et al. \(2001\)](#) and [Wang, Berglund, Olfson, and Kessler \(2004\)](#) found that a typical treatment delay for persons with alcohol use disorder was at least a decade.

Understanding barriers and deterrents to treatment experienced by persons with alcohol use disorders is important to developing accessible and acceptable treatment. Historically, most studies have operationalized treatment seeking as a dichotomous variable (i.e., according to whether or not treatment was obtained). These have been succeeded by studies that conceptualize treatment seeking as a process that comprises a series of decisions ([Jordan & Oei, 1989](#), [Mojtabai et al., 2002](#), [Pringle, 1982](#), [Saunders, 1993](#), [Saunders, 1996](#), [Simpson & Tucker, 2002](#)).

This study utilized the model of the treatment-seeking process used in [Saunders, 1993](#), [Saunders, 1996](#) and depicted in [Fig. 1](#). As reviewed below, the model proposes that treatment seeking consists of four steps and that, at each step, there exist possible barriers to the next step. Barriers are herein categorized as either “person-related” or “treatment-related.” Person-related barriers comprise cognitive and emotional factors that hinder decisions that ultimately lead to treatment seeking (such as negative attitudes toward treatment or failure to realize the seriousness of the drinking problem). Treatment-related barriers are aspects of the treatment (such as its format or cost) or the treatment system (such as unavailability or access difficulty) that hinder treatment seeking.

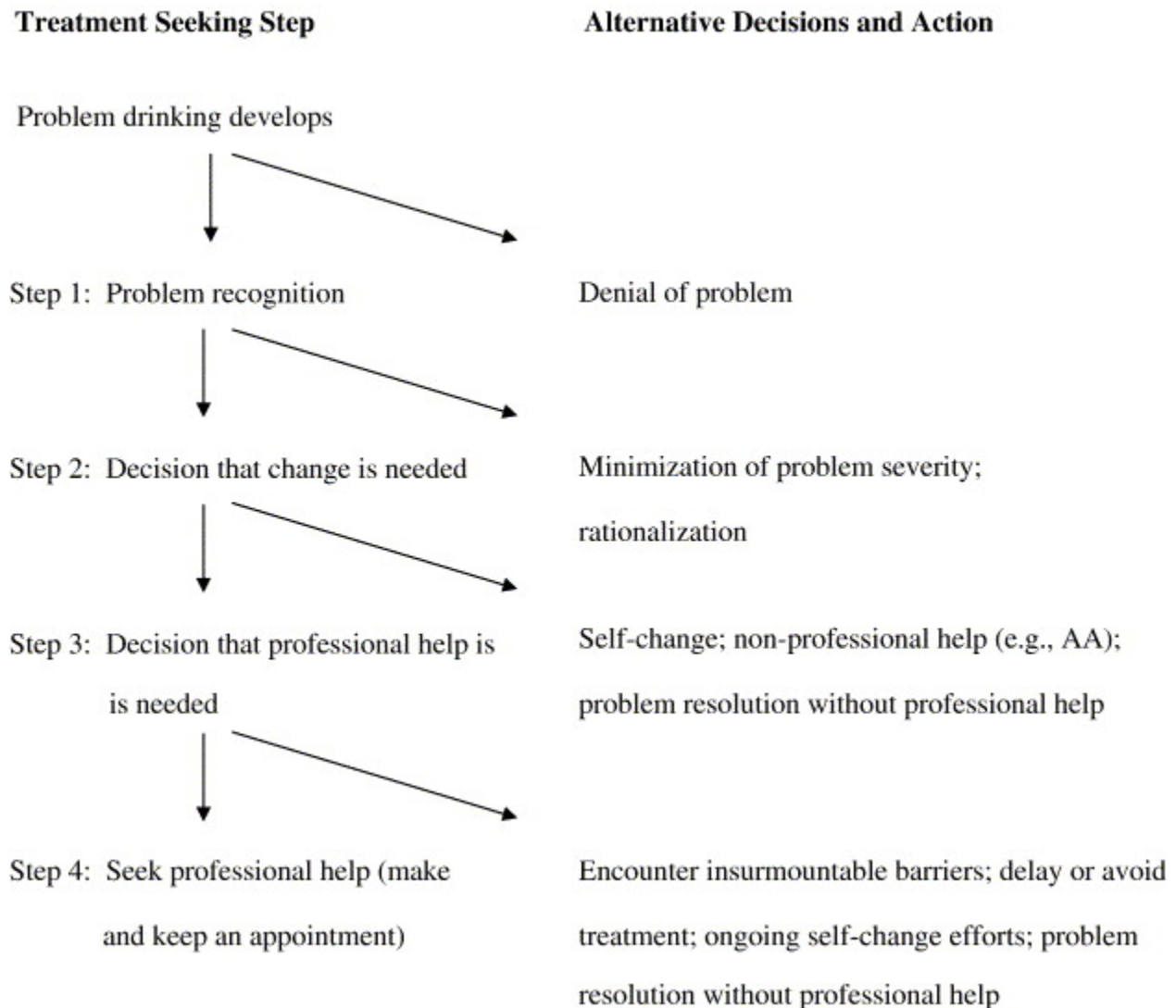


Fig. 1. A model of the steps of the treatment-seeking process.

1.1. Barriers at the early steps of treatment seeking

The process of treatment seeking begins when a person with an alcohol use disorder recognizes or admits that there is a problem (see [Fig. 1](#)). Once a person with a drinking problem realizes that the problem exists, the second step in the treatment-seeking process is deciding that change is necessary. Many of those who have a drinking problem simply refuse to acknowledge it or somehow fail to recognize it. They are classically identified as being in denial—a major barrier to treatment seeking. Similarly, many individuals are aware that they have a drinking problem, but they do not easily (or do not ever) decide that change is needed. They may engage in minimization of the negative impact that drinking has on their lives, or they may rationalize that problems are ultimately caused by other factors.

Both of these initial steps are primarily cognitive activities. As such, person-related barriers are most relevant at these steps, including stigma ([Cunningham et al., 1993](#), [Grant, 1997](#)).

[Corrigan \(2004\)](#) distinguished self-stigma, which comprises damage to self-esteem, and public stigma, which is based on one's fear of others' reactions. Self-stigma is most relevant during these first two decisions (i.e., that one has a problem and must change).

Researchers have reported that the intensity or frequency of negative life events and psychosocial impairments related to drinking is predictive of treatment seeking (e.g., [Brennan & Moos, 1996](#), [Brennan et al., 1994](#), [Finney & Moos, 1995](#), [Kaskutas et al., 1997](#), [Proudfoot & Teesson, 2002](#), [Tucker, 1995](#)), suggesting that denial and embarrassment are eventually overwhelmed by a desire to reduce the problems associated with drinking (e.g., [Hingson et al., 1982](#), [Thom, 1986](#)). Indeed, drinking-related problems are more predictive of treatment seeking than the drinking behavior itself, such as amount or frequency ([Hajema et al., 1999](#), [Kaskutas et al., 1997](#)). Recognizing a problem with alcohol use and the need for change is also more likely when emotional distress is substantial and when comorbid psychiatric problems exist, such as depression and anxiety ([Green-Hennessy, 2002](#), [Kirchner et al., 2000](#)). Interventions to redress the problems of denial and minimization have been developed. For example, motivational interviewing ([Miller & Rollnick, 1991](#)) was designed to confront problem drinkers about the actual impact that drinking has, as well as to address ambivalence about the need for change. There is extensive evidence of the efficacy of this intervention ([Burke, Arkowitz, & Dunn, 2002](#)).

1.2. Barriers at the latter steps of treatment seeking

The third step or decision in the process of treatment seeking is deciding that professional intervention is needed, and the last step in the process is deciding to seek treatment. These decisions do not inevitably follow the first two ([Saunders, 1993](#), [Saunders, 1996](#)). Prior to deciding that professional intervention is required, most persons with a drinking problem attempt other strategies for addressing the problem and, indeed, many successfully resolve the problem on their own (e.g., [King & Tucker, 1998](#), [Tucker et al., 1994](#)).

Both person-related and treatment-related barriers are encountered at the latter two steps. One person-related barrier, public stigma or fear of others' reactions, is relevant at the latter steps wherein, by definition, one must publicly acknowledge a drinking problem and the need for treatment ([Corrigan, 2004](#)). Doubting the need for treatment seems to be a fairly universally experienced person-related barrier ([Fox et al., 2001](#), [Hingson et al., 1982](#), [Mojtabai et al., 2002](#)), as is fear of being embarrassed or even being stigmatized by admitting the need for treatment or by actually attending treatment ([Cunningham et al., 1993](#), [Grant, 1997](#), [Thom, 1986](#)). Achieving these steps is also hindered by ignorance about treatment availability and incorrect notions about the requirements for acceptance into treatment ([Grant, 1997](#), [Tucker, 1995](#)). Negative attitudes toward treatment are commonplace person-related barriers ([Grant, 1997](#)), but several researchers have found that a preference for solving the problem without treatment was a major factor in delaying or avoiding treatment regardless of attitudes about its effectiveness ([Cunningham et al., 1993](#), [Tucker, 1995](#)). In summary, person-related barriers are commonplace at the latter two steps.

Although not relevant at the first two steps, treatment-related barriers have been shown to be important at the latter steps. Such barriers include poor or inadequate availability of services,

the cost or format of treatment, insurance problems, and other access issues (e.g., [Brown et al., 2000](#), [Fox et al., 1995](#), [Tucker et al., 2004](#)). Treatment-related barriers have consistently been shown to be less relevant to treatment seeking than person-related variables (see [Grant, 1997](#)). However, there are some indications that the influence of such factors as financial concerns is greater for persons with alcohol use disorders who are female ([Weisner, 1993](#)), minority, or of relatively low socioeconomic status (e.g., [Allen, 1995](#), [Beckman & Amaro, 1986](#), [Brown et al., 2000](#), [Snowden, 2001](#)).

1.3. This study

In summary, research suggests that important differences in the experience of barriers exist at different steps of the treatment-seeking process. For example, it seems intuitively likely that barriers to problem recognition are different from barriers to deciding that treatment is needed. However, there is little direct research addressing this issue, largely because research has not discriminated in detail the steps in the process.

This study assessed the barriers to treatment experienced by persons with alcohol use problems at the latter steps of the treatment-seeking process (as it has been conceptualized in [Fig. 1](#)). To be specific, persons with alcohol use problems who recognized that they had a problem severe enough to warrant professional intervention but who had not yet sought treatment were contrasted to persons with alcohol use problems who had completed the process (i.e., who were seeking treatment). All were asked to indicate the impact of person-related and treatment-related barriers. It was hypothesized that a variety of variables would distinguish these two groups, including negative consequences associated with excessive drinking and emotional distress. It was also hypothesized that treatment-related barriers would be less relevant than person-related barriers at this latter stage of treatment seeking.

2. Materials and methods

2.1. Treatment setting

The study was conducted at an outpatient behavioral health center in Milwaukee, WI. The center included a specialty clinic for the treatment of alcohol and drug problems. The clinic was part of an integrated system of outpatient clinics and hospitals. In the year prior to the study, the clinic saw more than 500 outpatients for alcohol, drug, or combined alcohol/drug abuse and dependence. All study participants were interviewed at the clinic.

2.2. Participant recruitment

Two groups of persons exhibiting alcohol-related problems were enrolled into the study. Persons in treatment for alcohol problem ($n = 80$; "Treatment Seekers") were recruited from a private treatment facility via posters in waiting areas. Persons engaging in problematic drinking behavior but not seeking treatment ($n = 65$; "Comparison Controls") were recruited via newspaper advertisements. To be eligible for this study, participants had to be 21–75 years of age (inclusive); able to read English at grade 6 level; and obtained a total score of 8 or more on the Alcohol Use Disorders Identification Test (AUDIT) on screening evaluation.

In addition, to be eligible for this study, potential participants had to identify themselves as having a drinking problem for which treatment was needed. This criterion was evaluated using two screening strategies. First, potential participants had to respond “Yes” to the question, “Whether you have done so or not, do you think you need professional help for this problem?” In addition, potential participants were presented with an explanation of the study's model of the treatment-seeking process (see [Fig. 1](#)) and asked to “place themselves” at one of the steps in the model. Potential participants were considered eligible only if they placed themselves at either the third or the fourth step. That is, eligible comparison control participants had to place themselves at step 3, wherein they asserted the need for professional help for a drinking problem. Eligible treatment seekers had to place themselves at step 4, wherein they asserted having already sought treatment for a drinking problem. An additional inclusion criterion for potential participants to be in the Treatment Seekers group was that the research interview must occur within 2 weeks of their first appointment.

Potential participants were excluded for: use of opioids or other psychoactive drugs in the month prior to study enrollment; identification of drug use as the primary problem; and engaging in treatment for either a drug or an alcohol problem within the last 6 months.

In 18 months of data collection, 329 possible participants were screened. Of these, 150 did not meet study criteria because their drinking was not severe enough (their AUDIT score was less than 8; $n = 46$), they had been in treatment within the last 6 months ($n = 22$), they were currently in treatment for more than 2 weeks ($n = 46$), or they did not acknowledge that they needed professional help for their drinking problem ($n = 36$). Of the 179 participants who were eligible and invited to be part of the study, 22 declined to participate and 12 were scheduled for research appointments but failed to come.

2.3. Participants

Treatment Seekers had a mean age of 43.1 years ($SD = 8.9$). They were predominantly male (62 were male and 18 were female), unmarried (20 were never married; 30 were separated, divorced, or widowed; and 30 were married or remarried), and Caucasian (66 were Caucasian, 11 were African American, and 3 were Hispanic/Latino), with 13.2 mean years of education attained ($SD = 2.0$). Most (71.7%) had children and were employed either full time (76.4%) or part time (10.4%). Regarding prior treatment, all Treatment Seekers had been in a previous outpatient treatment and 36.3% had been in a previous inpatient treatment. Ten of the Treatment Seekers (12.5%) were court-mandated to their current treatment.

Comparison Controls had a mean age of 44.1 years ($SD = 9.1$). They were also predominantly male (39 were male and 26 were female), unmarried (21 were never married; 23 were separated, divorced, or widowed; and 21 were married or remarried), and Caucasian (44 were Caucasian, 19 were African American, and 2 were Hispanic/Latino), with 13.7 mean years of education attained ($SD = 1.9$). Most (67.7%) had children and were employed either full time (73.4%) or part time (10.9%). Regarding prior treatment, none of the Comparison Controls had been in a previous outpatient treatment, whereas 21.5% had been in a previous inpatient treatment. None of the Comparison Controls reported being court-mandated to treatment.

2.4. Measures

2.4.1. Alcohol use and consequences

Severity of recent alcohol use was assessed using AUDIT and Form 90. AUDIT is a 10-item interview with questions assessing the amount and frequency of drinking, symptoms of dependence, and problems caused by alcohol. It has adequate psychometric properties and proven validity in identifying individuals whose alcohol consumption has become hazardous or harmful to their health ([Bohn, Babor, & Kranzler, 1995](#)). The Form 90 structured interview ([Miller W. R., 1996](#)) assesses the quantity and frequency of alcohol consumption over the previous 90 days. Respondents report the number of drinks consumed and the time period in which they were consumed on a daily and on a weekly basis. Two measures from Form 90 were derived for the study: “drinks per average drinking day” (DDD) and “percent days abstinent in the last 90 days” (PDA).

Participants' experience of alcohol-related adverse events was assessed using the Drinker Inventory of Consequences (DrInC; [Tonigan & Miller, 1993](#)), a self-report questionnaire listing 50 possible negative consequences of drinking behavior, such as hurting others or financial harm. Items are rated on a five-point Likert scale, with higher scores indicating more adverse consequences of drinking, and items are summed to yield a total score and five subscale scores (physical, interpersonal, intrapersonal, impulse control, and social responsibility subscales).

2.4.2. Emotional distress

Participants' emotional distress was measured using the global severity index (GSI) of the Brief Symptom Inventory ([Derogatis, 1993](#)). The instrument comprises 53 items describing psychiatric problems, such as appetite problems and panic attacks. Items are rated on a five-point Likert scale, ranging from *not at all* to *extremely*. Items are averaged to create the GSI, with higher scores indicating more distress. The GSI has good psychometric properties, including high internal consistency and test–retest reliability, and it has been shown to have adequate construct, convergent, and discriminant validity ([Derogatis, 1993](#)).

2.4.3. Barriers to treatment

Participants' experience of barriers to treatment was evaluated via an interview created for this study. Twenty-one items listing barriers to treatment, based on the categories used by previous researchers ([Schober & Annis, 1996](#), [Sobell et al., 1991](#)), were read to them. There were 10 person-related barriers and 11 treatment-related barriers, as shown in [Table 1](#). To avoid order effects, two versions of the same interview, which varied the order of the barriers, were used. In both versions, the two categories of barriers were presented in mixed order. Participants were instructed: “People often encounter a variety of obstacles or barriers in making a decision to seek treatment for a drinking problem.” Participants indicated the extent to which each barrier “affected or influenced” their decision to seek treatment for a drinking problem. Each was rated on a five-point Likert scale with the following options: 0 = *not at all*; 1 = *a little bit*; 2 = *somewhat*; 3 = *quite a bit*; 4 = *a great deal*.

Table 1. Endorsement of barriers

| Barriers | All participants <i>M (SD)</i> | Treatment Seekers <i>M (SD)</i> | Comparison Controls <i>M (SD)</i> | <i>t</i> Test/Mann-Whitney <i>U</i> test |
|--|-----------------------------------|------------------------------------|--------------------------------------|--|
| All barriers | 1.1 (0.8) | 1.0 (0.7) | 1.3 (0.8) | -2.50 [□] |
| All person-related barriers | 1.3 (0.9) | 1.2 (0.8) | 1.6 (1.0) | 2.55 [□] |
| All treatment-related barriers | 0.9 (0.8) | 0.8 (0.7) | 1.1 (0.9) | 1.97 [□] |
| Person-related barriers | | | | |
| Wanting to handle the problem on your own | 2.0 (1.4) | 1.6 (1.4) | 2.6 (1.2) | 4.52 ^{□□□} |
| Believing you should be able to handle the problem on your own, without professional help | 1.8 (1.5) | 1.3 (1.4) | 2.4 (1.4) | 4.55 ^{□□□} |
| Feeling embarrassed that you have a drinking problem | 1.5 (1.4) | 1.5 (1.4) | 1.5 (1.3) | |
| Not having the motivation to stop drinking | 1.4 (1.3) | 1.2 (1.2) | 1.8 (1.4) | 2.88 ^{□□} |
| Worrying that you would be looked down on by others if you admitted you had a drinking problem | 1.4 (1.4) | 1.3 (1.3) | 1.5 (1.4) | |
| Feeling unable to share your drinking problem with others | 1.2 (1.2) | 1.2 (1.2) | 1.2 (1.2) | |
| Feeling embarrassed that you needed professional help | 1.2 (1.3) | 1.1 (1.3) | 1.3 (1.4) | |
| Feeling unable to talk about your drinking problem | 1.1 (1.2) | 1.0 (1.1) | 1.2 (1.3) | |
| Worrying that you would be looked down on by others if you sought professional help for a drinking problem | 1.1 (1.3) | 1.0 (1.2) | 1.2 (1.4) | |
| Not having reasons to stop drinking | 0.8 (1.1) | 0.6 (1.0) | 1.1 (1.2) | 3.07 ^{□□} |
| Treatment-related barriers | | | | |
| Not believing that treatment would really help | 1.2 (1.2) | 1.0 (1.1) | 1.4 (1.3) | 2.16 [□] |
| Worrying or believing that you could not afford treatment | 1.1 (1.4) | 1.0 (1.4) | 1.2 (1.5) | |
| Worrying or believing that treatment would be too costly | 1.1 (1.4) | 1.0 (1.4) | 1.2 (1.5) | |
| Being unaware of what treatments are available | 1.0 (1.1) | 0.9 (1.1) | 1.2 (1.2) | |

| Barriers | All participants <i>M (SD)</i> | Treatment Seekers <i>M (SD)</i> | Comparison Controls <i>M (SD)</i> | <i>t</i> Test/Mann–Whitney <i>U</i> test |
|--|-----------------------------------|------------------------------------|--------------------------------------|--|
| Being unaware of what treatment would involve | 1.0 (1.1) | 0.9 (1.0) | 1.2 (1.1) | |
| Difficulty of coming to treatment because of time required | 1.0 (1.2) | 0.9 (1.1) | 1.3 (1.4) | |
| Being unsure of whether your insurance covered the treatment | 0.9 (1.3) | 0.7 (1.2) | 1.1 (1.4) | |
| The distance needed to be traveled to get to treatment | 0.9 (1.1) | 0.9 (1.2) | 0.8 (1.1) | |
| Unsure of how to go about obtaining treatment | 0.8 (1.1) | 0.7 (1.0) | 0.9 (1.3) | |
| Believing that treatment is ineffective or does not work | 0.8 (1.1) | 0.6 (0.9) | 1.1 (1.3) | 2.65 ^{□□} |
| The clinic location | 0.5 (1.0) | 0.5 (0.9) | 0.6 (1.0) | |

Notes. 0 = Not at all; 1 = a little bit; 2 = somewhat; 3 = quite a bit; 4 = a great deal.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

2.5. Procedure

All participants provided informed consent to be part of the study and were treated in accordance to the standards of the Institutional Review Board of Marquette University. All data were collected at a single research interview, following procurement of informed consent. Interviews with Treatment Seekers occurred within 2 weeks of the initiation of treatment. Interviews took between 1.5 and 3.5 hours to complete (the average was just more than 2 hours). Participants were paid \$75 at the completion of the interview.

2.6. Statistical analyses

In evaluating differences between these two groups of problem drinkers, *t* tests (under conditions of equal variances between variables) and Mann–Whitney *U* tests (under conditions of unequal variance) were conducted. To reduce experimentwise error, a Bonferroni correction was implemented when multiple analyses were conducted. When appropriate, multivariate logistic regression analyses were conducted.

3. Results

3.1. Participant characteristics

Analyses were conducted to evaluate whether Treatment Seekers and Comparison Controls were similar on demographic variables. When evaluating such potential confounding differences between groups, type I error is of less concern than type II error; thus, Bonferroni

corrections were not calculated. The two groups were significantly different regarding sex ($\chi^2 = 5.20, p = .023$), as the Comparison Controls comprised more females than the Treatment Seekers. The two groups also differed with respect to both prior outpatient treatment and court-mandated current treatment: None of the Comparison Controls reported either prior outpatient treatment or current court-mandated treatment.

3.2. Alcohol use and consequences

3.2.1. Drinking history and current behavior

Participants were asked to recall their age when they first had an alcoholic drink and to estimate their age when the drinking problem began. The two groups reported statistically similar ages for both events. Treatment Seekers reported that they had their first drink at a mean age of 13.3 years ($SD = 3.9$), whereas Comparison Controls reported a mean age of 13.0 years ($SD = 3.7; t = 0.59, p = .55$). Treatment Seekers estimated that their drinking problem began at a mean age of 26.8 years ($SD = 10.7$), whereas Comparison Controls estimated a mean age of 25.2 years ($SD = 10.2; t = 0.93, p = .35$) for that event.

The average AUDIT score of Treatment Seekers ($M = 21.27, SD = 6.19$), was statistically similar to that of the Comparison Controls ($M = 20.26, SD = 6.47; t = 0.95, p = .34$). From Form 90, Treatment Seekers' average DDD ($M = 6.48, SD = 16.19$) and PDA ($M = 7.52, SD = 19.24$) were similar to those of Comparison Controls' DDD ($M = 10.52, SD = 23.15; t = -1.17, p = .08$) and PDA ($M = 3.08, SD = 9.89; t = 1.77, p = .24$).

3.2.2. Negative consequences

On the total DrInC scale, Treatment Seekers' average score ($M = 71.19, SD = 31.74$) was similar to that of the Comparison Controls ($M = 62.42, SD = 31.28; t = 1.66, p = .10$). To further explore the role of negative consequences in prompting treatment-seeking behavior, individual subscales of the DrInC were evaluated via six t tests. Treatment Seekers obtained higher scores on the subscale intrapersonal consequences (Treatment Seekers: $M = 18.14, SD = 8.96$; Comparison Controls: $M = 14.66, SD = 8.71; t = 2.35, p = .02$), but the difference was not considered statistically significant after Bonferroni correction (which required that the probability be less than .008 to be considered statistically significant).

3.3. Emotional distress

Differences between Treatment Seekers and Comparison Controls in reported emotional distress were evaluated by examining the differences in scores on the GSI of the Brief Symptom Inventory. Results indicated that Treatment Seekers ($M = 75.8, SD = 23.9$) had significantly higher GSI scores than Comparison Controls ($M = 57.1, SD = 38.5; t = 3.41, p < .001$).

3.4. Barriers to alcohol treatment

3.4.1. Overall endorsement

The average endorsements of each of the barriers are shown in [Table 1](#), grouped according to person-related and treatment-related barriers and in order of the frequency of endorsement. The two most frequently endorsed barriers for all the participants were person-related (“wanting to handle the problem on your own” and “believing you should be able to handle the problem on your own, without professional help”). The least endorsed barrier was treatment-related (“the clinic location”).

3.4.2. Group differences

To examine further the potential role of individual barriers, each was examined in *t* tests contrasting the two groups. Results significant at the .05 level are highlighted in [Table 1](#), although Bonferroni correction for person-related barriers resulted in an $\alpha = .005$, whereas the correction for treatment-related barriers resulted in an $\alpha = .0045$. After statistical correction, only two person-related barriers were endorsed significantly differently by the two groups (“wanting to handle the problem on your own” and “believing you should be able to handle the problem on your own, without professional help”).

Three scales were created by calculating the mean endorsement of all barriers (the total barriers scale score), of all person-related barriers (the person-related barriers scale score), and of all treatment-related barriers (the treatment-related barriers scale score; see [Table 1](#)). Internal consistencies of the scales were adequate (Cronbach's $\alpha = .92$, .88, and .87, respectively). The person-related barriers scale had a significantly higher average endorsement than the treatment-related barriers scale by all participants ($t = 6.12$, $p < .001$), but also by both Treatment Seekers ($t = 3.97$, $p < .001$) and Comparison Controls ($t = 4.72$, $p < .001$). As shown in [Table 1](#), Comparison Controls' average score on the total barriers scale, the person-related barriers scale, and the treatment-related barriers scale was higher than the average scores of Treatment Seekers.

3.4.3. Multivariate analyses

Logistic regression was performed by entering all variables found to differentiate the two groups: sex, education level, the intrapersonal consequences subscale of the DrInC, the GSI score from the Brief Symptom Inventory, and scores from the person-related barriers scale and the treatment-related barriers scale. The results are shown in [Table 2](#). With the exception of the treatment-related barriers scale, all of the variables were significant predictors in the final equation, which correctly classified 81.0% of the Treatment Seekers and 62.5% of the Comparison Controls (72.7% overall).

Table 2. Logistic regression predicting group membership

| Variables | <i>B</i> | <i>SE</i> | Wald |
|------------------|----------|-----------|-------------------|
| Sex (0 = female) | 0.85 | 0.43 | 3.87 ^a |

| Variables | <i>B</i> | <i>SE</i> | Wald |
|------------------------------------|----------|-----------|-------|
| Years of education | 0.20 | 0.10 | 4.38□ |
| Person-related barriers | 0.73 | 0.31 | 5.43□ |
| Treatment-related barriers | 0.23 | 0.31 | 0.54 |
| Intrapersonal consequences (DrInC) | −0.06 | 0.03 | 4.14□ |
| GSI (emotional distress) | −0.02 | 0.01 | 6.44□ |

Model $\chi^2 = 37.22$, $p < .001$.

* $p < .05$.

4. Discussion

Despite the availability of numerous effective interventions, most persons with an alcohol-related problem do not obtain appropriate professional treatment. This study examined barriers to treatment that differentiated problem drinkers at the latter stage of treatment seeking. All participants had accomplished three of the four steps of the help-seeking model: All acknowledged a drinking problem (step 1) that needed to be changed (step 2) and required treatment (step 3). The study evaluated differences between those who had and those who had not actually sought care.

Some differences between the Treatment Seekers and the Comparison Controls were unrelated to barriers. First, Treatment Seekers were more likely to be male—a frequent research finding. Why females are underrepresented in alcohol treatment centers is under investigation. Whether this sex difference is mediated by a differential experience of barriers, in particular treatment-related variables ([Amaro et al., 1987](#), [Thom, 1987](#), [Wells et al., 2002](#)), could not be addressed in this study because of the relatively few number of females participating. In addition, Treatment Seekers were more likely to have had prior treatment experience and to be court-mandated to treatment. Also intriguing was the finding that current treatment was related to previous treatment. It may be that previous treatment reduces certain barriers to further treatment (such as lack of knowledge about treatment). It might also be argued that those who have refused treatment in the past continue to refuse it presently, and it is noted that the groups did not differ in drinking severity or history (including the age of first problem with drinking).

Prior studies suggest that negative interpersonal consequences of drinking were most relevant in differentiating problem drinkers who do and who do not seek treatment ([Hajema et al., 1999](#), [Kaskutas et al., 1997](#)). This study found that problems caused by drinking are relevant to the treatment-seeking process. These results also suggest, however, that treatment barriers and emotional distress may be more relevant, at least at the latter stages of treatment seeking. The relevance of emotional and intrapsychic distress was seen in the relatively elevated scores (for those who sought treatment) on the DrInC intrapersonal consequences subscale and on the GSI.

4.1. The importance of personal barriers and the role of self-stigma

Prior research suggests that person-related barriers are the most important predictors of treatment seeking, but it was hypothesized that treatment-related barriers would be more relevant toward the end of the treatment-seeking process. It was expected that, as treatment was actually approached by problem drinkers, then treatment-related issues (e.g., availability, access, and cost) would become relatively more important than person-related issues (e.g., shame). Two treatment-related barriers did distinguish participants who did and who did not seek treatment—both related to doubts about treatment effectiveness. However, the results of multivariate analyses suggested that person-related barriers are more important than treatment-related barriers, even at this latter stage of the treatment-seeking process. A preference for self-help or attempting to solve the problem without treatment was the most commonly endorsed barrier to treatment by all participants, but was also the best predictor of treatment seeking. Other barriers that distinguished those who did and who did not seek treatment were lack of motivation and reasons to stop. Although there is increasing concern that access and financial barriers prevent treatment utilization (e.g., [Mechanic et al., 1995](#), [Miller, 1996](#)), these data suggest that psychological and motivational barriers remain substantially more important throughout the process.

These findings can be interpreted to suggest that self-stigma is more important than public stigma throughout the process ([Corrigan, 2004](#)). Public stigma leads persons to shun treatment to avoid harmful reactions on the part of the society, and public stigma might be expected to be most pertinent at the latter stages when the person must openly admit the need for treatment. Public stigma concerns can be clearly seen in these study results, as participants endorsed fear, embarrassment, and worry about “being looked down on by others” (see also [Cunningham et al., 1993](#), [Grant, 1997](#)). However, these concerns did not distinguish those who ultimately sought treatment from those who did not. Self-stigma leads persons to shun treatment to avoid “diminished self-esteem, self-efficacy, and confidence in one's future” ([Corrigan, 2004, p. 618](#)). Early in the treatment-seeking process, self-stigma might prevent someone from admitting that a problem exists or that change is needed. For example, the results indicated that embarrassment about having a problem was one of the most frequently endorsed barriers (although it did not distinguish the two groups). Instead, self-stigma at the latter stage of the treatment-seeking process appears to be most relevant. Self-stigma is seen in the preference for handling the problem without treatment, perhaps reflecting misplaced self-efficacy and fear of challenges to one's self-esteem.

4.2. Study limitations

The study is limited due to the nonrandom samples of participants, who were recruited from a treatment facility or from newspaper advertisements. On the other hand, the samples are unique in that all participants admitted that they had an alcohol problem for which they needed help. The generalizability of these results is also limited because of the small number of participants who were female or of ethnic minority. Some studies suggest that these populations are more vulnerable to treatment-related barriers ([Amaro et al., 1987](#), [Thom, 1987](#), [Wells et al., 2002](#)). The participants who sought treatment differed from those who did not on prior treatment-seeking experiences and on being court-ordered to treatment. Controlling for

these variables in future studies (e.g., by examining persons who are seeking treatment for the first time only) would be a useful undertaking. In addition, it is noted that several problem drinkers in treatment were excluded from the study because they did not acknowledge either that they had a drinking problem or that professional intervention is needed. More research is needed to understand the failure of persons who misuse alcohol to acknowledge the problem or the need for help. Finally, the study did not assess the potential roles of barriers to treatment adherence. Whether preference for self-help or doubts about the effectiveness of treatment negatively impact treatment adherence needs to be evaluated.

4.3. Implications for treatment and treatment-seeking facilitation

These results support the assertion that the primary barriers to treatment seeking reside within the person, whereas treatment factors are not as important. More specifically, the results suggest that the primary barriers to treatment may be person-related factors that operate toward the end of the treatment-seeking process. The prospect of willingly entering a treatment environment seems to present a self-stigmatizing challenge to problem drinkers, threatening their sense of control and self-esteem. It would likely benefit practitioners to be acutely aware of this during the intake and early treatment process. Directly addressing concerns about embarrassment and, in particular perhaps, concerns about loss of self-esteem related to the person “needing” treatment might alleviate the sense of stigma and might diminish the likelihood of failure of treatment engagement or premature termination.

These results suggest that public health messages must emphasize the importance and effectiveness of treatment. Messages must highlight aspects of treatment that are perhaps not widely recognized, including the fact that clinicians are highly trained experts who specialize in the difficult process of changing lifelong habits of thinking and behavior. It might be particularly useful to emphasize that treatment ultimately enhances feelings of self-efficacy and self-determination, which are marred by problem drinking and its negative consequences. Such messages should directly address concerns about desires to “handle the problem on your own,” perhaps by directly appealing to the development of requisite skills for such aspirations.

If the stigma associated with treatment can be reduced, then people at earlier stages of alcohol-related problems—who are less likely to be physically dependent and to have irreparably damaged their intimate, occupational, and social functioning—might more willingly seek help.

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